Medi-Cal Rx Billing Tips

Version 2.0

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1.0 Introduction

On January 1, 2022, the California Department of Health Care Services (DHCS) transitioned all Medi-Cal pharmacy services from Managed Care Plan (MCP) to fee-for-service. The following information is to be used by pharmacy providers and prescribers as a "quick reference guide" to provide billing tips for claim submission to Medi-Cal Rx.

Starting January 1, 2023, Cal MediConnect (CMC) plans will transition to Medicare Medi-Cal Plans (MMPs or Medi-Medi Plans). Drug coverage will continue to be processed through coordination of benefits (COB) with Medicare Part B and Part D prior to coverage through Medi-Cal. Pharmacy benefits for Medi-Cal will be processed through Medi-Cal Rx as the payor of last resort for drugs/products that are **specifically** excluded from Medicare Part D.

Additional billing and claim processing information, specifically COB and other healthcare coverage, can be found in the *Medi-Cal Rx Provider Manual* and the *National Council for Prescription Drug Programs (NCPDP) Payer Specifications Sheet* on the Medi-Cal Rx Web Portal.

For information about Medi-Cal Rx covered products, refer to the Covered Products Lists on the Forms & Information page on the Medi-Cal Rx Web Portal.

NOTE: This document is not all-inclusive of the changes occurring with the fee-for-service transition.

2.0 Claim Submission Changes

Claim Submission		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
Pen Needles	• Pen Needles, when used in conjunction with injection pens to deliver injectable medications, will be administered through the Medi-Cal Rx fee-for-service delivery system. This is billable by fee-for-service pharmacy providers via Point of Sale (POS) or on a pharmacy claim form (Universal Claim Form [UCF], California Specific Pharmacy Claim Form [30-1]) using the contracted product's 11-digit NDC.	*Medi-Cal Rx Provider Manual (Section 13.0 – Medical Supplies)*
Code I Restrictions for Diagnosis	• The applicable diagnosis code (NCPDP Field ID: 424-DO) may be entered on the claim to satisfy the requirement *or* Submission Clarification Code (SCC) (NCPDP Field 420-DK) 7 – Medically Necessary.	*Medi-Cal Rx Provider Manual (Section 11.1 – Code 1 Restrictions)*

Claim Submission		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
Cost Ceiling	• Claims are subject to a $10,000 cost ceiling (certain drugs are exempt – see *Section 15.6 – Cost Ceiling* in the *Medi-Cal Rx Provider Manual*). **NOTE:** Pharmacy providers may call the Medi-Cal Rx Customer Service Center (CSC) at 1-800-977-2273 for a real-time override if specific criteria are met. Alternatively, pharmacy providers can request a prior authorization (PA) that, if approved, will eliminate the need to call every time the prescription is filled.	*Medi-Cal Rx Provider Manual (Section 15.6 – Cost Ceiling)*
Dual Eligible Part B COB	• For pharmacy claims which do not automatically cross over, COB claim submission is allowed via POS. Enter "444444" in the Other Payer ID field (NCPDP Field ID: 340-7C) to identify this as a Part B COB claim. **NOTE:** Not to be used when claim is paid under Medicare Part D benefit.	*Medi-Cal Rx Provider Manual (Section 10.1.2 – Medicare Part B Crossover Claims)*

Claim Submission		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
Dual Eligible Part D COB	• Medicare Part D drugs or copays are not covered by Medi-Cal. • For drugs that are specifically excluded from Part D, pharmacies can submit a primary claim to Medi-Cal Rx without having to get a response from Medicare. • For drugs that receive either a **Reject Code 65 (Patient is Not Covered)** or **A5 (Not Covered Under Part D Law)** from Medicare, pharmacies can submit a claim to Medi-Cal Rx with OCC = 3 (Other Coverage Exists Claim Not Covered). • For other Part D COB scenarios, refer to the *Medi-Cal Rx Provider Manual*.	*Medi-Cal Rx Provider Manual (Section 10.1.4 – Medicare Part D COB)*
DUR Conflict Codes	• Claims submitted **must** include **each** Drug Use Review (DUR) conflict code on the claim. • Reason for Service Code (NCPDP Field ID: 439-E4) • Professional Service Code (NCPDP Field ID: 440-E5) • Result of Service Code (NCPDP Field ID: 441-E6)	*Medi-Cal Rx Provider Manual (Section 16.0 – Drug Use Review [DUR])*

Claim Submission		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
Emergency Fills (up to 14-day supply)/Claims	• Emergency claims (up to 14-day supply) can be submitted via paper *or* POS. • Must submit Level of Service (NCPDP Field ID: 418-DI) – "3"	*Medi-Cal Rx Provider Manual (Section 15.7 – Emergency Fills)*
Declared State of Emergency Fills	• Use SCC (NCPDP Field ID: 420-DK) – "13"	*Medi-Cal Rx Provider Manual (Section 15.7.3 – Protocol for Override UM During State of Emergency)*
Quantity Prescribed/ Incremental Fills	A single prescription for a Drug Enforcement Administration (DEA) Schedule II drug may be filled in multiple increments on separate claims (known as an incremental fill) only if **ALL** of the following conditions are met: • All incremental fills **must** be processed by the **same** pharmacy. • Total quantity dispensed for all incremental fills must not exceed the total quantity prescribed by the prescriber. Any quantity remaining on the prescription after 30 days from the date prescribed **cannot** be filled.	*Medi-Cal Rx Provider Manual (Section 15.3 – Incremental Fills)*

Claim Submission		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
Morphine Milligram Equivalent (MME)	• Claims submitted for Opioid products > 90 MME will reject. • Claims submitted for Opioid products >/= 500 MME will deny and a PA will be required.	*Medi-Cal Rx Provider Manual (Section 15.1.3 – Controlled Substance Policy)*
Newborn Claims	• Claims for newborns may be submitted via POS *or* paper. • Pharmacy providers submitting newborn pharmacy claims when using the mother's ID number via POS are required to input a "3" in the Patient Relationship Code field (NCPDP Field ID: 306-C6) and a PA Type Code (Prior Authorization Type Code [PATC]) (NCPDP Field ID: 461-EU) of "8" to identify the claim as a newborn claim.	*Medi-Cal Rx Provider Manual (Section 8.2.2 – Newborns)*

Claim Submission		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
Opioid Management	• Claims submitted for controlled drug products, including opioids (DEA Schedule 2-5) will have a maximum days' supply of 35 days. Claims submitted for > 35 days will require a PA. (This does **not** apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products.) • Claims submitted for all injectable forms of opioids will require a PA. • **New start** quantity per day limits and quantity per fill limits apply. Refer to the *Medi-Cal Rx Provider Manual* for additional information on these limits.	*Medi-Cal Rx Provider Manual (Section 15.1.3 – Controlled Substance Policy)*
Patient Residence	A Patient Residence value **must** be entered to identify a beneficiary as Long-Term Care. Pharmacy providers must use one of the following Patient Residence values (NCPDP Field ID: 384-4X): • 3 – Nursing Facility • 9 – Intermediate Care Facility/Individuals with Intellectual Disabilities. **NOTE:** Patient Location (NCPDP Field ID: 307-C7) is no longer utilized to identify Long-Term Care.	*Medi-Cal Rx Provider Manual (Section 8.2.1 – Long-Term Care Claims Processing)*

Claim Submission		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
Prior Authorization(s)	Authorizations use the term "Prior Authorization" or "PA." **NOTE:** Information regarding PAs, including PA request methods, can be found in the *Medi-Cal Rx Provider Manual* (see next column for specific section reference).	*Medi-Cal Rx Provider Manual (Section 14.0 – Prior Authorization Overview, Request Methods, and Adjudication)*
Submission Clarification Codes (SCCs)	Multiple SCCs (NCPDP Field ID: 420-DK) may be entered on a single claim (if necessary). **NOTE:** Maximum SCCs allowed on a single claim is three (3).	*NCPDP Payer Specifications Sheet (Section 1.1 – B1/B3 – Claim Billing/Claim Re-Bill Request)*

Additional information can be found in the *Medi-Cal Rx Provider Manual*, *NCPDP Payer Specifications Sheet*, etc. on the Medi-Cal Rx Web Portal.

3.0 Claim Form Changes

To obtain forms or information on fax numbers, addresses, or submission methods, visit the Medi-Cal Rx Provider Portal on the Medi-Cal Rx Web Portal and from the **Forms & Information** page, click the **Provider Manual** tab.

NOTE: Pharmacy providers submitting a Charpentier claim **must** write/enter CHARPENTIER on the form.

Paper Claim Forms		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
California Specific Compound Pharmacy Claim Form (30-4)	When submitting a *California Specific Compound Pharmacy Claim Form (30-4)* pharmacies **must** leave Box 25 (Route of Administration [ROA]) **BLANK**. The Systematized Nomenclature of Medicine (SNOMED) value **must** be entered in Box 48 (Specific Details/Remarks). **NOTE:** SNOMED values can be found in the *Medi-Cal Rx Provider Manual*.	*Medi-Cal Rx Provider Manual (Section 19.2.2.1 – Completion Instructions for California Specific Compound Pharmacy Claim Form [30-4])*

Paper Claim Forms		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
Claim Inquiry Form (CIF)	Claim Inquiry Forms are used after submitting a claim to request one of the following: • Adjustment • Reconsideration • Tracer Pharmacy providers can access the CIF via the Medi-Cal Rx Web Portal on the Forms & Information page.	*Medi-Cal Rx Provider Manual (Section 19.4 – Medi-Cal Rx Provider Claim Inquiry Form (CIF) (DHCS 6570))*
Prior Authorization Form (formerly known as a Treatment Authorization Request [TAR])	The *Medi-Cal Rx Prior Authorization Request Form* should be completed and sent to the Medi-Cal Rx vendor via fax or mail. Pharmacy providers can access the *Medi-Cal Rx Prior Authorization Request Form* on the Forms & Information page. **NOTE:** Other acceptable PA request forms: • Medi-Cal Form 50-1 • Medi-Cal Form 50-2 • California Form 61-211	*Medi-Cal Rx Provider Manual (Appendix E – Acceptable Medi-Cal Rx PA Request Forms)*

Paper Claim Forms		
Change Taking Place	***Effective* 01/01/2022**	**Corresponding Reference Document**
Provider Claim(s) Appeals	The *Provider Claim Appeal Form* must be completed and sent to the Medi-Cal Rx vendor via fax or mail. Pharmacy providers can access the *Provider Claim Appeal Form* on the Forms & Information page.	*Medi-Cal Rx Provider Manual (Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form [DHCS 6571])*
Universal Claim Form	Pharmacy providers are able to submit an NCPDP Universal Claim Form for pharmacy claims (including compound pharmacy claims). Universal Claim Forms can be ordered from the NCPDP website.	*Medi-Cal Rx Provider Manual (Section 19.1 – Universal Claim Form, Version D.0)*

4.0 NCPDP Payer Specification Changes

The BIN and Processor Control Number (PCN) have changed.

Transaction Header Segment			
Transaction Type	Transaction Code 1Ø3-A3	BIN 1Ø1-A1	PCN 1Ø4-A4
Claim Billing Request	B1	022659	6334225
Claim Billing Reversal Request	B2		
Claim Rebill	B3		
Eligibility Verification Request	E1		
Prior Authorization Reversal	P2		
Prior Authorization Inquiry	P3		
Prior Authorization Request Only	P4		
Drug Pricing Inquiry	B1	022667	393

Additional information can be found in the *Medi-Cal Rx Provider Manual*, *NCPDP Payer Specifications Sheet*, etc. on the Medi-Cal Rx Web Portal.

NCPDP Field Name and Number	NCPDP Field Values *Effective* 01/01/2022	Comments/Situation
1.1 B1/B3 – Claim Billing/Claim Rebill Request		
Group ID 301-C1 Required.	MediCalRx	
Patient Relationship Code 306-C6 Required.	1 = Cardholder 3 = Child 4 = Other (use for Transplant Donor)	Submit "3" for newborn claims using mother's Medi-Cal Cardholder ID. Submit "4" for claims for a transplant donor, when using transplant recipient's Medi-Cal Cardholder ID.
Pregnancy Indicator 335-2C Required when patient is pregnant.	Blank = Not Specified 1 = Not Pregnant 2 = Pregnant	Required if the patient is known to be pregnant.
Patient Residence 384-4X Required when needed to identify Long-Term Care.	3 = Nursing Facility 9 = Intermediate Care Facility/Individuals with Intellectual Disabilities	Required for Long-Term Care.
Number of Refills Authorized 414-DF Required.	0 = No Refills Authorized 1-99 = Authorized Refill Number	Required to indicate the number of refills authorized.

NCPDP Field Name and Number	NCPDP Field Values *Effective* 01/01/2022	Comments/Situation
Submission Clarification Code Count 354-NX Required when needed for Code 1 or Compounds.	Maximum Count of 3	SCC 2 is used for *initial* dose of COVID-19 vaccine. SCC 6 is used for *final* dose of COVID-19 vaccine. SCC 7 is used for Code 1. SCC 8 is used for Compounds. SSC 20 is used to identify a 340B drug.
Unit of Measure 600-28 Required.	EA = Each GM = Grams ML = Milliliters	
Level of Service 418-DI Required for emergency claims.	3 = Emergency	Required when self-certifying the Emergency Statement is met for a 72-hour emergency supply on POS claims.
Prior Authorization Type Code 461-EU Required when needed for Newborn Claims or Pricing PAs.	1 = Prior Authorization (PA) (used for Medi-Cal pricing) 8 = Newborn Claims	Do not submit the PATC "1" unless communicating PA has been approved to override Medi-Cal pricing. Submit "8" for newborn claims.
Prior Authorization Number Submitted 462-EV Required when needed for PA.		Not needed to identify the PA.

NCPDP Field Name and Number	NCPDP Field Values *Effective* 01/01/2022	Comments/Situation
Compound Type 996-G1 Required when the claim is a compound.		Required when needed to clarify the type of compound.
Patient Paid Amount Submitted 433-DX Not Required – Do Not Send.		Not required. Do not send.
Other Payer Reject Count 471-5E Required when OCC is "3".	Maximum count of 5	Required if Other Payer Reject Code (472-6E) is used.
Other Payer Reject Code 472-6E Required when OCC is "3".		Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (308-C8) = "3" (Other Coverage Billed – claim not covered).
2.1 B2 – Claim Reversal Request		
Other Coverage Code 308-C8 Required when OCC was submitted on the original claim that is being reversed.		Required when OCC was submitted on the original claim that is being reversed.

NCPDP Field Name and Number	NCPDP Field Values *Effective* 01/01/2022	Comments/Situation
Coordination of Benefits/Other Payments Count 337-4C Required when OCC was submitted on the original claim that is being reversed.	Maximum count of 9	Required when OCC was submitted on the original claim that is being reversed.
Other Payer Coverage Type 338-5C Required when OCC was submitted on the original claim that is being reversed.		Required when OCC was submitted on the original claim that is being reversed.
5.1 P4 – Prior Authorization Request Only Request		
Patient Relationship Code 306-C6 Required.	1 = Cardholder 3 = Child 4 = Other (use for Transplant Donor)	Input "3" for newborn claims using mother's Medi-Cal Cardholder ID. Input "4" when submitting claims for a transplant donor, when using transplant recipient's Medi-Cal Cardholder ID.
Patient Residence 384-4X Required when needed to identify Long-Term Care.	3 = Nursing Facility 9 = Intermediate Care Facility/Individuals with Intellectual Disabilities.	Required if this field could result in different coverage, pricing, or patient financial responsibility. Required for Long-Term Care.

5.0 Acronyms

Term	Definition
BIN	Bank Identification Number
CIF	Claims Inquiry Form
CMC	Cal MediConnect
COB	Coordination of Benefits
CSC	Customer Service Center
DEA	Drug Enforcement Administration
DHCS	California Department of Health Care Services
DUR	Drug Use Review
MCP	Managed Care Plan
MME	Morphine Milligram Equivalent
MMP/Medi-Medi Plans	Medicare Medi-Cal Plans
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
PA	Prior Authorization
PATC	Prior Authorization Type Code
PCN	Processor Control Number – A 10-digit number maintained by Magellan Medicaid Administration, Inc. (MMA) that is used for internal record keeping.
POS	Point of Sale
ROA	Route of Administration
SCC	Submission Clarification Code
SNOMED	Systematized Nomenclature of Medicine
TAR	Treatment Authorization Request
UCF	Universal Claim Form